

## Pressure Ulcer Prevention: Implementation Strategies

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## Prevention Program

- Prevention Program Assessment  
Include ALL staff?
  - ◆ Nursing (licensed and caregivers)
  - ◆ Dietary
  - ◆ Therapies
  - ◆ Physicians/Nurse Practitioners

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## Prevention Program

- ◆ The individual and family members
- ◆ Housekeeping, Activities, Maintenance, etc.
  - Assist with answering call lights
  - Monitor equipment
  - Notify appropriate staff if the individual is:
    - in one position too long
    - smells of urine or feces
    - has not been given hydration, meal tray, supplements

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## Prevention Program

- **Prevention Program Assessment**
  - Consider the unlicensed caregivers to drive the prevention program
    - ✓ Solicit feedback and ideas
    - ✓ Empowerment

Consistent assignments and universal workers

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## Assessing Programs

- **Break your pressure ulcer Prevention program down into two areas:**
  - Admission process
  - On-going Prevention Program
- **Utilize the Quality Improvement process when assessing each program**

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## Admission Program

- **Developing a task force for skin:**
  - Assess when and where your admissions are happening
  - When and who is inspecting the skin upon admission/within 24 hours (not just to the care setting, but also to the unit)
  - When and who is identifying the risk factors within 24 hours, and
  - When and who is care planning/implementing the interventions within 24 hours?
    - ✓ Reality – not what the policy and procedure states

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## Admission Process

- All care settings admission process (within the first 24 hours) should include:
  - A head to toe skin inspection by the **licensed** staff (ideal within 8 hours)
  - A risk assessment for the potential for skin breakdown
  - Development of a temporary plan of care
  - Communication to the caregivers

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## Admission Program

- **Admission Process Tips**

At a MINIMUM interventions within the first 24 hours should include:

  - ✓ Support surfaces (bed and W/C)
  - ✓ Turning & repositioning schedules
  - ✓ Incontinence care & keeping skin clean and dry
  - ✓ Heels elevated off bed
  - ✓ Dietary and therapy referrals
  - ✓ Access to topical dressings if admitted with pressure ulcers

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## Prevention Program Assessment

- Does your current prevention program include:
  - ❖ **On-going** Risk Assessments per care setting guidelines?
  - ❖ **On-going** skin inspections?
  - ❖ **On-going** updates to the plan of care?

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## Prevention Program Assessment

- Does your current prevention program include:
  - ❖ On-going communication and involvement with the direct caregivers?
  - ❖ How do the caregivers communicate skin concerns (verbally or written)?

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## Prevention Program Assessment

- Does your current prevention program include:  
Identified interventions/products for skin risk factors such as:
  - ✓ Pressure redistribution bed surface, including access to low-air-loss and air-fluidized beds if needed
  - ✓ Wheelchair cushions
  - ✓ Heel lift devices and/or pillows

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## Prevention Program Assessment

Identified interventions/products for skin risk factors such as:

- ✓ Barrier ointments/creams to protect from incontinence (are they accessible to the caregivers)
- ✓ Lifting and positioning devices
- ✓ Dietary supplements as appropriate
- ✓ A list of interventions to consider for potential risk factors, to help develop the plan of care

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## Prevention Program Assessment

- Do you have effective communication systems
  - ❖ Between shifts and between caregivers (last time turned & toileted at a minimum)?
  - ❖ Are interventions being communicated to the caregivers (turning schedules, heel lift, toileting, etc.)?
  - ❖ Between Units?
  - ❖ Between health care settings?

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## Prevention Program Assessment

- Do you have monitoring programs in place such as:
  - Monitoring turning and repositioning (sticky notes)
  - Monitoring toileting schedules
  - Assessment and confirmation that equipment is in place and functioning properly

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## Other Prevention Program Tips

- Do you have monitoring programs in place such as:
  - Monitor treatment books
  - Ensure IDT is being proactive and discussing high risk individuals (immobile, losing weight and incontinent)
  - Monitor daily cares to ensure they are inspecting the skin, doing proper peri-care, ROM, feeding/supplements, weights, I & O, etc.

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## Prevention Program Assessment

- Are you utilizing your Wound Care Nurse for prevention????
  - ❖ Monitoring that the risk assessment and skin observations are done at appropriate intervals
  - ❖ Monitoring that the plan of care reflects interventions being implemented and identified risk factors
  - ❖ Do the risk assessments, physician orders, caregiver assignment sheets and MDS/RAPS match the care plan?

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## Treatment Program Assessment

- Treatment Program Assessment
  - Do you have a system in place to ensure a new risk assessment gets done
  - Do you have a system in place to notify the Physician and family/designee of the development of a wound, if no progress in 2 weeks or when it declines
  - Do you have a system in place to initiate documentation of the wounds progress
  - Trigger to up-date the care plan & nursing assistants

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## Treatment Program Assessment:

- Treatment Program Assessment:
  - Do you have interventions and products in place for when a wound develops
    - Moisture dressings (i.e., hydrogels, hydrocolloids and transparent films)
    - Absorbative dressings (i.e., foams and calcium alginates)
    - Enzymatic debriders (usually perscription)
    - Access to adjunctive therapies (i.e., V.A.C., Infrared, E-Stim, Ultrasound, etc.)
    - Support surfaces
    - Air, gel or foam wheelchair cushions
    - Dietary supplementation

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## Treatment Program

- **Treatment Program Tips**
  - Monitor ALL nurses doing dressing changes and wound assessments
  - Monitor treatment records and documentation records
  - Monitor the Physician and NP orders, diagnosis and progress notes appropriate
  - Ensure IDT is actively discussing/identifying wounds not showing progress

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## Pressure Ulcer Assessment

- **DO** you nurses know how to identify the etiology of the ulcer (pressure versus vascular)
- **Do** your nurses know how to stage pressure ulcers utilizing the new NPAUP staging system
  - Purpose of staging is for consistent communication of depth of tissue destruction
  - Once staged, the ulcer should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures ([www.npuap.com](http://www.npuap.com))
  - To accurately complete the MDS, follow instructions provided

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## F314 Tag Common Performance Gaps

- **Failure to document resident refusal of care and treatment in care plan**
  - ☞ Document the date of discussion in care plan and put resident's request in care plan
  - ☞ Review quarterly, with re-admission and with change of condition

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### F314 Tag Common Performance Gaps

Documentation of refusal of cares should include:

- Discuss resident's condition
- Treatment options
- Expected outcomes
- Consequences of refusing treatment (pressure ulcer development, sepsis and even death)
- Offer relevant alternatives
- Recommend showing residents/families pictures of pressure ulcers

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### Educational Programs

- Recommend doing educational programs in this order
  - Prevention
  - Assessment and Documentation
  - Treatment Modalities
  - Lower Extremity Ulcers
- Do bedside follow up after educational programs
- Do education on orientation and periodically throughout the year

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### Skin Care Programs

*Overall, if you keep the resident's best interest in mind, your program will succeed!!!*

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## Resources

■ **Available Resources and Web Sites:**

[www.wocn.org](http://www.wocn.org) (Wound, Ostomy & Continence Nurse Society)

◆ Available Guidelines:

- Prevention and Management of Pressure Ulcers
- Management of Wounds in Patients with Lower-Extremity Arterial Disease
- Management of Wounds in Patients with Lower-Extremity Neuropathic Disease
- Management of Wounds in Patients with Lower-Extremity Venous Disease

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## Resources

■ **Available Resources and Web Sites:**

[www.ahrq.gov](http://www.ahrq.gov) (Agency for Health Care Research and Quality, formerly AHCPR)

◆ Call: 1-800-358-9295 for FREE guidelines:

- Clinical Practice Guideline Number 3: Pressure Ulcers in Adults: Prediction and Prevention
- Clinical Practice Guideline Number 15: Treatment of Pressure Ulcers
- Patient Guide for Pressure Ulcer Prevention

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## Resources

■ **Available Resources and Web Sites:**

🌀 [www.aawm.org](http://www.aawm.org) (American Academy of Wound Management) Has a list of Certified Wound Care Specialists

🌀 [www.npuap.org](http://www.npuap.org) (National Pressure Ulcer Advisory Panel)

🌀 [www.woundsource.com](http://www.woundsource.com) Great source to find wound care products and companies/vendors

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**Thanks for your participation!!!**

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